PUBLIC GOODS POOL
GENERAL INSTRUCTIONS FOR COMPLETING
PAYOR MONTHLY REPORTING FORMS

IMPORTANT NOTE: HARDCOPY MONTHLY REPORTS CAN ONLY BE USED FOR REPORTING PERIODS PRIOR TO JULY 1, 2005. ALL MONTHLY REPORTS COMMENCING JULY 1, 2005 MUST BE SUBMITTED ELECTRONICALLY.

Payors that have elected to remit their public goods liability directly to the Office of Pool Administration are required to use hardcopy forms or file electronically to calculate and remit monthly payments to the Public Goods Pools. Prior service year portions of the reports are available on the Web at:

www.health.state.ny.us/nysdoh/hcra/hcrahome.htm

A payor's monthly Public Goods Pool reporting submission must include only those surcharge and/or covered lives payment obligations relating to the service period during which the payor is an electing payor. Such payors must continue to remit surcharge obligations, relating to service periods that are not covered by a valid election, directly to designated providers of services. For example, payors whose elections to remit surcharges directly to the Public Goods Pools do not become effective until January 1st of the current year must not submit the previous service year portion of the report since they are required to continue to remit any applicable surcharges/assessments for such service periods to designated providers of services. Conversely, payors that rescind their election effective December 31st of the previous reporting year do not report their surcharge/assessment obligations for subsequent service periods on the Public Goods Pool report forms since they are required to remit any applicable surcharges/assessments for such service periods to designated providers of services.

Further, a payor's monthly Public Goods Pool reporting obligation does not cease when the payor rescinds its election application. The payor's monthly Public Goods Pool reporting obligation, for the service period during which the entity was an electing payor, will continue for a period of one year following the end of the year in which the election was rescinded or until all claims for such service period have been adjudicated. Once all claims have been adjudicated, the payor must submit a final monthly report and a completed Attachment 2.5 indicating the effective date when all claims were adjudicated. Additionally, a payor's monthly Public Goods Pool reporting obligation does not cease when the payor has a change of status (i.e. self-insured to fully insured). For important information concerning a payor's reporting obligations when the payor has a change of status, please refer to the specific forms located on the WEB.

Pursuant to the New York Health Care Reform Act of 1996, each service period's pool receipts are dedicated to specific purposes and for specific amounts. As a result:

- Monthly reports filed by payors must segregate patient services payments and the related surcharges into service period portions. For example, payors must include total patient service payments for services provided in 2002 in the 2002 portion of the report even if such payments are made in a subsequent service period. In addition, any prior period adjustments must be reported in the service period section of the report to which they apply. For example, a correction for an amount reported for service period 2002 must be reported as a prior period adjustment on the 2002 portion of the monthly report.

- Monthly reports filed by payors must segregate covered lives and related assessments into service year portions. Thus, adjustments necessary to covered lives information reported during a prior year must be reported on the appropriate year's form. For example, an adjustment for covered lives information reported during 2002 must be reported on the 2002 portion of the Report of Covered Lives Assessment. Under **no** circumstances should adjustments to covered lives payments reported for prior years be included in the current service year portion of the report.

Note that the guidance offered in these instructions is not all-inclusive. Please refer to the New York Health Care Reform Acts and related correspondence previously disseminated by the Department, which is available on the HCRA WEB site.

PAYOR CERTIFICATION FORM

MONTH/YEAR: Enter month and year for which data is being reported.

PAYOR NAME: Enter name of payor. The payor name is that of the incorporated entity, local government, or self-insured fund for which data is being reported. Enter the parent company name if the reporting submission applies to a parent company. Enter "See Attachment 1", if the reporting submission applies to a third-party administrator (TPA) and its represented organizations.

ADDRESS: Enter address of payor.

FED. TAX ID #: Enter federal identification number used by the payor for federal tax purposes.

TPA NAME/TPA FED. TAX ID #: Enter name of third party administrator (TPA) and their federal tax identification number, if payor utilizes a TPA for claims processing and payment.

COMPLETED BY/TITLE/TELEPHONE: Enter name, title and telephone number of the person who will be responsible for providing the Department related information regarding the payor's report form(s).

TYPE OF SUBMISSION: Check appropriate box to specify whether the certification and reporting submission is for 1) an insurer or self-insured fund acting on its own behalf; 2) a TPA and all of the represented organizations listed on Attachments 1 and 2; or 3) a parent company and all its related subsidiaries listed on Attachment 1.

REPORTING REQUIREMENTS: Indicate whether the certification and reporting submission pertains to the Report of Patient Services Payments and Surcharge Obligations and/or Report of Covered Lives Assessment by checking any appropriate box(es).

CERTIFICATION: Enter name and title of person who is certifying to the accuracy and correctness of the report form(s) submitted. Enter name of organization that employs the person signing the Certification form.

- Where the information being certified to has been supplied to a TPA by another entity, the TPA must obtain and maintain for audit purposes an attestation statement from an authorized person of such entity to the effect that the information is accurate and correct to the best of their knowledge and belief. **Note:** Authorized persons would be any person who is empowered to legally bind the organization to such commitments.

SIGNATURE/DATE: The person responsible for certifying the accuracy and correctness of the report form(s) submitted must sign and date the Certification form.

PRINT FULL NAME: Print or type name of person responsible for certifying the accuracy and correctness of the report form(s) submitted.

TELEPHONE NUMBER: Provide telephone number of individual signing the certification.

ATTACHMENT 1
TPA/Parent Company Reporting Forms - Identification of Represented Organization/Subsidiary Reporting Forms

MONTH/YEAR: Enter month and year for which data is being reported.

TPA OR PARENT COMPANY NAME/FEDERAL TAX ID #: Enter parent company name and federal tax identification number if the reporting submission applies to a parent company. Enter TPA name and federal tax identification number if the reporting submission applies to a TPA.

CONTACT/TELEPHONE #: Enter name and telephone number of person who will be responsible for providing the Department related information regarding the payor's report form(s).

PAYOR TYPE: Check appropriate box.

ORGANIZATION NAME/FEDERAL TAX ID#: List name and federal tax identification number of each entity being reported by the Parent Company or TPA.

TPAs only – For each entity listed, check the type of report(s) submitted and payment method (separate or combined check) by year. You must check at least one of the report type boxes (Patient Service Payment Report or Covered Lives Report) for the current and previous service years. Where a TPA is submitting a consolidated report on behalf of a parent company with a number of subsidiaries, the TPA must list the name and federal tax identification number of the parent company and each subsidiary. A separate Attachment 1 must be completed for each parent company.

ATTACHMENT 2
TPA Summary of Represented Electing Entities With No Public Goods Liability

MONTH/YEAR: Enter month and year for which data is being reported.

TPA NAME/FEDERAL TAX ID #: Enter name of TPA and their federal tax identification number.

CONTACT/TELEPHONE #: Enter name and telephone number of person who will be responsible for providing the Department related information regarding the payor's report form(s).

ORGANIZATION NAME/FEDERAL TAX ID#: List name and federal tax identification number of each represented entity that has no activity to report for the reporting month or is submitting the reporting forms separately on its own behalf. Where a TPA is representing a parent company with a number of subsidiaries, the TPA must list the parent company and each represented subsidiary that has no activity to report for the reporting month or is submitting the reporting forms separately on its own behalf.

List only those entities that have no activity to report for the month for all HCRA service periods (i.e., commencing with the 1997 service period through the current service period) and/or those entities that are submitting the Certification and reporting forms on their own behalf. If an entity has activity to report for one or more HCRA service periods, the entire report must be completed in accordance with the instructions.

IMPORTANT NOTE: Do not list payors that have no covered lives liability or credit for the report month due to apportionment on this attachment. Payors that apportion the cost of their covered lives assessments with another payor must report the covered lives subject to apportionment and their respective apportionment percentage on Lines C through H of the Report of Covered Lives Assessment. The Report of Covered Lives Assessment must be completed even where the payor's apportionment percentage is zero.

For each entity listed, enter an "X" in the appropriate box under each of the categories provided (i.e., Patient Service Payments and Covered Lives).

REPORT OF PATIENT SERVICES PAYMENTS AND SURCHARGE OBLIGATIONS

GENERAL INSTRUCTIONS
On the top of the form, check all the reporting circumstances which apply.

For the current service year portion of the report:

Box 1: Enter an "X" if the payor has made no patient services payments during the report month for services rendered during the current service year and has no adjustments to patient services payments previously reported for the current service year.

Box 2: Enter an "X" if the payor has a) no statutory obligation to the Professional Education Pool or b) a statutory obligation to the Professional Education Pool but had no covered lives of residents of New York State during the report month and no adjustments to covered lives information previously reported for the current service year. **IMPORTANT NOTE:** Only those payors that a) are NOT specifically mentioned in PHL Section 2807-s (1-a)(b) as having a professional education pool surcharge or covered lives obligation or b) had no New York State residents on their membership rolls for all or any part of the report month and no prior period adjustments to covered lives information previously reported for the current service year may check this box. This box may not be used where a payor's share under an apportionment agreement is zero. Payors that apportion their covered lives obligations with another payor must report the covered lives subject to apportionment and their respective apportionment percentage on Lines C through H of the Report of Covered Lives Assessment.

Box 3: Enter an "X" if the payor's Report of Covered Lives Assessment is being submitted separately by the fund or a TPA.

For the previous service year portion of the report:

Box 1: Enter an "X" if the payor has made no patient services payments during the report month for services rendered during the previous service year and has no adjustments to patient services payments previously reported for the previous service year.

Box 2: Enter an "X" if the payor has no adjustments for covered lives information previously reported for the previous service year.

Box 3: Enter an "X" if the payor's Report of Covered Lives Assessment is being submitted separately by the fund or a TPA.

Note that report heading definitions below apply to all service years

MONTH/YEAR: Enter month and year for which data is being reported.

PAYOR NAME: Enter name of payor. The payor name is that of the incorporated entity, local government, or self-insured fund for which data is being reported.

FEDERAL TAX ID#: Enter federal identification number used by the payor for federal tax purposes.

TPA NAME/TPA FEDERAL TAX ID #: Enter TPA's name and federal tax identification number, if the payor utilized a TPA for claims processing and payment.

COLUMNAR DESCRIPTIONS

Column A - Description: This column itemizes total patient services payments and the related surcharge liability. **Note:** Refer to Payor Report for applicable surcharge percentage.

Patient services payments subject to the surcharges include all monies paid during the report month to designated providers of service, including capitation payments allocable to the particular service, less refunds, for discharges occurring or for visits made or services performed on or after January 1st, or contracted service obligations for periods on or after January 1st, of the report service year.

Excluded from the surcharge requirements are payments for physician practice or faculty practice plan discrete billings for private practicing physician services, laboratory tests performed on laboratory specimens collected outside New York State, residential health care facility services, inpatient and outpatient hospice services, adult day health care services, home care services, and services provided to subscribers of an HMO operating in accordance with Article 43 of the Insurance Law or Article 44 of the Public Health Law in situations where such HMO operates the clinic or laboratory providing the service (this applies whether or not such services are covered services by the HMO). Services provided to Medicare beneficiaries are also excluded except where a payor is making payments to a designated provider of service as a result of a person's exhaustion of Medicare benefits, or lack of Medicare benefits for a particular service. In these instances, the services are subject to the surcharge. Additionally, payments related to patients covered under the Federal Employees Health Benefits Act (FEHBA) and certain federal government payors such as Job Corps, CHAMPUS/TRICARE and VA are excluded from the surcharge requirements.

Pursuant to the provisions of the New York Health Care Reform Act of 2000 (HCRA 2000), surcharges are eliminated for referred ambulatory clinical laboratory hospital visits made or services performed on and after October 1, 2000. Referred (ordered) ambulatory care laboratory services are defined as clinical laboratory services provided to non-registered patients upon the order and referral of a qualified physician, physician's assistant, dentist, or podiatrist to test or diagnose a specimen taken from a patient. For purposes of the specific service being ordered for a specific patient, the specified provider ordering the service may not be employed by or under contract to provide direct patient care for the facility.

Referred (ordered) ambulatory care laboratory services do not include clinical laboratory services provided to a patient admitted to any of such hospital's inpatient units; an emergency outpatient defined as one who is admitted to the emergency, accident or equivalent service of the hospital (Title 10, Sect. 441.104); nor clinical laboratory services provided to a clinic outpatient defined as one who is registered with a formally organized hospital service unit known as a clinic (Title 10, Sect. 441.65).

Column B - Inpatient Hospital: This column is to be used to report patient services payments and the related surcharge liability for all inpatient services provided by general hospitals.

Column C - Outpatient Hospital: This column is to be used to report patient services payments and related surcharge liability for all outpatient services provided by general hospitals including referred ambulatory services, emergency services, ambulatory surgical services, hospital based and clinic laboratory services, and all other hospital and health-related services. Note that payments to hospital based laboratories or laboratories housed in comprehensive primary health care clinics must be reported in either Column C or Column E (Comprehensive Primary Health Care Clinic).

Column D - Freestanding Ambulatory Surgery: This column is to be used to report patient services payments and the related surcharge liability for all ambulatory surgical services of freestanding diagnostic and treatment centers providing ambulatory surgical services**.** Note that payments to a comprehensive primary health care clinic for ambulatory surgical services must be reported in Column E (Comprehensive Primary Health Care Clinic).

Column E - Comprehensive Primary Health Care Clinic: This column is to be used to report patient services payments and the related surcharge liability for all services of freestanding diagnostic and treatment centers providing a comprehensive range of primary health care services. Note that payments to hospital based laboratories or laboratories housed in comprehensive primary health care clinics must be reported in either Column E or Column C (Outpatient Hospital).

Column F - Freestanding Clinical Laboratory: This column appears only on the 1997 through 2000 service year portions of the report since it is to be used to report patient services payments and the related surcharge liability for **or on account of clinical laboratory visits made or services** (relating to human specimens) **performed prior to October 1, 2000** [1] by freestanding clinical laboratories issued a permit pursuant to Title V of Article 5 of the Public Health Law. Note that payments to hospital based laboratories or laboratories housed in comprehensive primary health care clinics must be reported in Column B (Hospital Outpatient Services) and Column E (Comprehensive Primary Health Care Clinic), respectively.

A list of the aforementioned designated providers subject to the surcharges is available on the WEB. Please note however, that the list of freestanding clinical laboratories may include clinical laboratories owned and operated by hospitals and comprehensive primary health care clinics.

LINEAR DESCRIPTIONS

Instructions apply to both service year portions of the Report of Patient Services Payments and Surcharge Obligations.

Line 1 - Patient Services Payments Subject to the Surcharge: The following instructions apply to Lines 1(a) through 1(d).

Line 1(a) - Current Month: This line is to be used for reporting patient services payments made during the report month that are subject to the surcharge. Payments must be reported according to the categories listed in Columns B through E. Patient services payments subject to the surcharge include payments to designated providers by New York State governmental agencies, local governmental agencies (of New York State) **ONLY** for services provided to correctional facility inmates, Health Maintenance Organizations (HMOs) or Prepaid Health Services Plans (PHSPs) for services provided to Medicaid beneficiaries enrolled in the HMO or PHSP, and approved organizations for services provided to subscribers eligible for the Family Health Plus Program pursuant to Title 11-D of Article 5 of the Social Services Law.

Line 1(b) - Prior Period Adjustment: This line is to be used for reporting adjustments due to a reporting error or omission in a prior month for patient services payments subject to the surcharge. The adjustments must be reported according to the categories listed in Columns B through E. The adjustment amounts may be either positive or negative but may not result in the Total Public Goods Pool Liability Payable to be less than zero. As a result, previous overpayments may have to be spread out over a number of months. Detailed records are to be maintained since all data is subject to audit.

[1] Pursuant to the provisions of HCRA 2000, surcharges are eliminated for or on account of freestanding clinical laboratory services and on referred laboratory services provided by hospitals and/or comprehensive clinics on and after October 1, 2000.

If a payor does not normally segregate these amounts individually, but maintains net amounts only within the payor's books and records, the payor may report such net amounts on Line 1(c) only (i.e., Lines 1(a) and 1(b) need not be completed).

Line 1(c) - Adjusted Patient Services Payments: Line 1(a) plus or minus Line 1(b).

Line 1(d) - Surcharge Liability: Multiply the individual amounts on Line 1(c) by the applicable surcharge. Enter the result in the appropriate column on Line 1(d).

Line 2 - Patient Services Payments Subject to the Surcharge: The following instructions apply to Lines 2(a) through 2(e).

Line 2(a) - Current Month: This line is to be used for reporting patient services payments made during the report month that are subject to the surcharge. The payments must be reported according to the categories listed in Columns B through E. Patient services payments subject to the surcharge include payments by corporations organized and operating in accordance with Article 43 of the Insurance law, organizations operating in accordance with the provisions of Article 44 of the Public Health Law, corporations that are commercial insurers licensed in New York State, self-insured funds, payors pursuant to the comprehensive motor vehicle insurance reparations act, the workers' compensation law, the volunteer firefighters' benefit law and the volunteer ambulance workers' benefit law, other insurers not licensed or organized under New York State statute, and any other rate, charge, or negotiated rate payment payor. Do not include payments for patient services provided to persons who are eligible for payments as beneficiaries of Title XVIII of the federal Social Security Act (Medicare) except where the payor has made payments to a designated provider of service as a result of a person's exhaustion of Medicare benefits, or lack of Medicare benefits for a particular service. In these instances, the services are subject to the surcharge and should be reported on this line. Additionally, do not include payments related to patients covered under the Federal Employees Health Benefits Act (FEHBA) and certain federal government payors such as Job Corps, CHAMPUS/TRICARE and VA.

Line 2(b) - Prior Period Adjustment: This line is to be used for reporting adjustments due to a reporting error or omission in a prior month for patient services payments subject to the surcharge. The adjustments must be reported according to the categories listed in Columns B through E. The adjustment amounts may be either positive or negative but may not result in the Total Public Goods Pool Liability Payable to be less than zero. As a result, previous overpayments may have to be spread out over a number of months. Detailed records are to be maintained since all data is subject to audit.

If a payor does not normally segregate these amounts individually, but maintains net amounts only within the payor's books and records, the payor may report such net amounts on Line 2(c) only (i.e., Lines 2(a) and 2(b) need not be completed).

Line 2(c) - Adjusted Patient Services Payments: Line 2(a) plus or minus Line 2(b).

Line 2(d) - Surcharge Liability: Multiply the individual amounts on Line 2(c) by the applicable surcharge. Enter the result in the appropriate column on Line 2(d).

Line 2(e) – Co-Payment and Deductible Surcharge Payments: Enter all surcharges the third-party payor is remitting directly to the Department’s Office of Pool Administration for patient co-payment and deductible payments, which would otherwise be paid to a provider in accordance with the second billing example on the Department of Health website at www.health.state.ny.us/nysdoh/hcra/examples.htm.

Payors directly remitting surcharge amounts attributable to patient co-payment and deductible payments must have procedures in place to adequately notify the billing provider of such action in a timely manner.

Line 3 - Total: Add the individual amounts on Lines 1(d), 2(d) and 2(e) and enter the result in the appropriate column on Line 3.

Line 4 - Total Surcharge Obligation on Patient Services Payments: Add the individual amounts on Line 3 and enter the result on Line 4.

REPORT OF COVERED LIVES ASSESSMENT

GENERAL INSTRUCTIONS FOR COMPLETING THE CURRENT SERVICE YEAR PORTION OF THE REPORT OF COVERED LIVES ASSESSMENT

On top of the form, check all the reporting circumstances which apply.

Box 1: Enter an "X" if the payor has a) no statutory obligation to the Professional Education Pool or b) a statutory obligation to the Professional Education Pool but had no covered lives of residents of New York State during the report month and no adjustments to covered lives information previously reported for the current service year. **IMPORTANT NOTE:** Only those payors that a) are NOT specifically mentioned in PHL Section 2807-s (1-a)(b) as having a professional education pool surcharge or covered lives obligation or b) had no New York State residents on their membership rolls for all or any part of the report month and no prior period adjustments to covered lives information previously reported for the current service year may check this box.
This box may not be used where a payor's share under an apportionment agreement is zero. Payors that apportion their covered lives obligations with another payor must report the covered lives subject to apportionment and their respective apportionment percentage on Lines C through H of the Report of Covered Lives Assessment.

Box 2: Enter an "X" if the payor has made no patient services payments during the report month for services rendered during the current service year and has no adjustments to patient services payments previously reported for the current service year.

Box 3: Enter an "X" if the payor's Report of Patient Services Payments and Surcharge Obligations is being reported separately by the fund or a TPA.

Covered Lives – Lines (A) and (B): Enter the number of individual covered lives and family unit covered lives residing in New York State during the report month, for whom the payor provides coverage for inpatient hospital services, which were included on the payor's membership rolls for all or any part of the reporting month, by region.

Line (A) # Individuals: Enter the number of individual covered lives.
Line (B) # Family Units: Enter the number of family unit covered lives.

These numbers should include any members on your rolls on the first day of the month plus any additions during the month.

Apportionment of Covered Lives – Lines (C) through (H): For payors that have reached an agreement to apportion the cost of their covered lives assessments with another inpatient payor providing unduplicated coverage for a single contract holder, and only for those payors that submitted apportionment agreements as part of their election application, data would be entered in this section of the form. All apportioning entities must be electing payors and the resultant apportionment between such electing payors must add up to 100% of the covered lives being apportioned. The payor must identify the number of covered lives, from within the total number of covered lives reported in Section I on Lines (A) and (B), which are the subject of apportionment.

Line (C) # Individuals Subject to Apportionment: Enter the total number of individual covered lives subject to apportionment.
Line (F) # Family Units Subject to Apportionment: Enter total the number of family unit covered lives subject to apportionment.

The apportionment percentage is the percentage of assessment cost which the reporting entity will be paying in the HCRA period. Where a payor has multiple apportionment agreements, the apportionment percentage entered on Lines (D) and (G) should reflect a composite percentage weighted to reflect the relative number of covered lives in each agreement. An example weighted average apportionment calculation is provided on the last page of these instructions. The apportionment percentages reported must reflect the agreements submitted as part of the payor's election application.

Line (D) Apportionment Percentage: Enter the apportionment percentages for individual covered lives.
Line (G) Apportionment Percentage: Enter the apportionment percentages for family unit covered lives.

Line (E) Apportioned # of Individual Covered Lives: Line (C) x Line (D).
Line (H) Apportioned # of Family Unit Covered Lives: Line (F) x Line (G).

Net Covered Lives – Lines (I) and (J): Net covered lives after apportionment and before prior period adjustments are derived by the following calculation: total number of covered lives less covered lives subject to apportionment plus apportioned covered lives.

Line (I) Net # Individuals: (Line A - Line C) + Line E.
Line (J) Net # Family Units: (Line B - Line F) + Line H.

Net Covered Lives - Prior Periods – Lines (K) and (L): For the January monthly report only, make no entry on Lines (K) and (L) since prior period adjustments do not apply to the current service year portion of the January monthly report. For the February through December monthly reports, enter the net number of individual and family unit covered lives under or (over) reported for prior periods (Prior Period Adjustments) by region on Lines (K) and (L), respectively. The net number of covered lives under or (over) reported for prior periods must reflect any apportionments if the lives being adjusted were previously subject to apportionment. The adjustment(s) may not result in the Total Public Goods Pool Liability Payable to be less than zero. As a result, previous overpayments may have to be spread out over a number of months.

For example, if 10 covered lives were being retroactively deleted for a month and pursuant to an apportionment agreement, this payor shared costs at a 50 percent level, only 5 lives would be shown on this section of the report. Prior period adjustments include retroactive additions and deletions to membership.

Note that retroactive deletions apply only when the individual or family unit is being retroactively deleted for full monthly periods. For example, if a covered life was originally included in the January 2002 through June 2002 monthly reports and was retroactively deleted effective January 5, 2002 the prior period adjustment would only reflect the deletion for the months of February through June 2002 since covered lives payments are due for any plan participant on the membership rolls for all or any part of a month.

Total Covered Lives – Lines (M) and (N): For the January monthly report only, carry the amounts forward from Lines (I) and (J) to Lines (M) and (N), respectively. For the February through December monthly reports, add the regional amounts reported on Line (I) to the respective amounts reported on Line (K) and enter the result on Line (M) and add the regional amounts reported on Line (J) to the respective amounts reported on Line (L) and enter the result on Line (N).

Annual Assessment Rate – Lines (O) and (P): The regional covered lives annual assessment rates for individual and family unit covered lives are provided in Line (O) and Line (P), respectively. These rates may not be changed by reporting entities.

Annual Assessment – Lines (Q) through (T):

Line (Q) Individual Unit: Line (M) multiplied by Line (O).
Line (R) Family Units: Line (N) multiplied by Line (P).
Line (S) Totals: Line (Q) plus Line (R).
Line (T) Monthly Payment Liability: Line (S) divided by 12.

Total Covered Lives Liability for the Month – Line VIII: The total covered lives liability for the month is the sum of the regional amounts entered on Line (T).

GENERAL INSTRUCTIONS FOR COMPLETING PRIOR SERVICE YEAR PORTIONS OF THE REPORT OF COVERED LIVES ASSESSMENT

On the top of the form, check all the reporting circumstances which apply.

For the previous service year portion of the report:

Box 1: Enter an "X" if the payor has no adjustments to covered lives information previously reported for the previous service year.

Box 2: Enter an "X" if the payor has made no patient services payments during the report month for services rendered during the previous service year and has no adjustments to patient services payments previously reported for the previous service year.

Box 3: Enter an "X" if the payor's Report of Patient Services Payments and Surcharge Obligations is being reported separately by the fund or a TPA.

The only amounts to be reported on prior service year portions of the Report of Covered Lives Assessment are prior period adjustments. Thus, the instructions for prior service year portions of the Report of Covered Lives Assessment begin with Lines (M) and (N).

Total Covered Lives - Lines (M) and (N): Enter the net number of covered lives under or (over) reported for prior periods (Prior Period Adjustments), by region. The net number of covered lives under or (over) reported for prior periods must reflect any apportionments if the lives being adjusted were previously subject to apportionment. The adjustment(s) may not result in the Total Public Goods Pool Liability Payable to be less than zero. As a result, previous overpayments may have to be spread out over a number of months. For an example, please refer to pages 10 & 11 of instructions under "Net Covered Lives - Prior Periods – Lines (K) and (L)".

Line (M) # Individuals (Prior Period Adjustment): Enter the number of individual covered lives under or (over) reported during a prior reporting period(s).
Line (N) # Family Units (Prior Period Adjustment): Enter the number of family unit covered lives under or (over) reported during a prior reporting period(s).

Annual Assessment Rate - Lines (O) and (P): The regional covered lives annual assessment rates for individual and family unit covered lives are provided in Line (O) and Line (P), respectively. These rates may not be changed by reporting entities.

Annual Assessment – Lines (Q) through (T):
Line (Q) Individual Unit: Line (M) multiplied by Line (O).
Line (R) Family Units: Line (N) multiplied by Line (P).
Line (S) Totals: Line (Q) plus Line (R).
Line (T) Monthly Payment Liability: Line (S) divided by 12.

Total Covered Lives Liability for the Month – Line VIII: The total covered lives liability for the month is the sum of the regional amounts entered on Line (T).

WIRE TRANSFERS

Payors may wire transfer monthly Public Goods Pool payments to the Department's Office of Pool Administration. Payors must complete and submit the Wire Transfer form. Payors that wire transfer their Public Goods Pool payment to the Department's Office of Pool Administration must fax a copy of the completed Wire Transfer form to the Office of Pool Administration 24 hours prior to completing the wire transfer. Additionally, payors must submit a copy of the completed Wire Transfer form with the applicable Certification and reporting form(s). Please follow closely the instructions listed at the bottom of the Wire Transfer form.

Example - Weighted Average Apportionment Calculation

NYC Region	1,000 Lives - All Individual 100 Lives Subject to Apportionment

Agreement #	# of Lives Subject to Apportionment.	This Payors Apportionment %	Apportioned Covered Lives
1	30	20%	6
2	50	30%	15
3	20	0%	0
Total	100		21

Apportionment Percentage = 21 / 100 or 21%

Or 21 lives at $116.04 = $2,436.84

PROOF:

Individual Covered Lives Rate	Agreement #	# of Lives Subject to Apport.	Full Assessment Calculation	Apportionment %	Apportioned Liability
$ 116.04	1	30	3481.20	20	$ 696.24
$ 116.04	2	50	5802.00	30	1,740.60
$ 116.04	3	20	2320.80	0	0
					$ 2,436.84